BULLETIN OF
THE NEW YORK ACADEMY
OF MEDICINE

VOL. 42, NO. 5 MAY 1966

SOCIOLOGICAL ASPECTS OF PSYCHOANALYSIS

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I

SIGMUND FREUD wished psychoanalysis to be considered a natural science, and he himself saw it as such. But this did not prevent it from being directly opposed to the traditional concept of medical therapy at that time. How was it possible that this psychoanalytic procedure, which was actually a new medical approach, could succeed against the powerful and successful traditional medicine?

Its success was certainly not due to its reception by traditional medicine. This reception was completely hostile, especially on the part of psychiatry. Only hesitatingly and against its will was medicine able to recognize psychoanalysis. It was much more the public demand for a new principle of treatment that determined the development and spread of psychoanalysis: a demand not only for a new principle of treatment but for a new goal of health.

We shall here be concerned with this demand and its development.

*Presented at a meeting of the Association for the Advancement of Psychoanalysis at The New York Academy of Medicine, April 28, 1965. This article is being published concurrently in the *American Journal of Psychoanalysis*, vol. 26, No. 1 (May), 1966.

We must become aware of the fundamental discrepancy between the therapeutic activity of psychoanalysis and the usual medical procedure: psychoanalysis functions in an area that is without meaning for traditional medicine, namely, the area of language dialogue, i.e., of mutual understanding. This psychoanalytic relationship and the expectation of health connected with it must appear strange to medicine, a discipline that treats the body of the patient to restore its functions.

First we shall sketch the psychoanalytic principle. Analyst and patient are partners. Even in the first settings of hypnosis, from which psychoanalysis arose, this realization became apparent. Josef Breuer and Freud came then to the insight that the authority of the doctor should not be used to produce improvements by posthypnotic suggestion, but that the hypnotic state should be used to give the patient a chance to say what occurs to him. Thus the patient is here recognized as a partner in the dialogue, who carries with him some knowledge that the analyst cannot know. But even the patient knows it only in such a way that he needs the communication of the psychoanalyst's presence to learn what became formulated under hypnosis. Thus he comes to have control over a part of his personality previously unavailable to him. A part of the knowledge that we carry with us is not conscious.

Freud recognized that certain urges are unconscious, but not ineffective. The access of such urges to motility is barred. They are not admitted to active life, but they strive toward it. This striving shows itself in phantasies and in dreams, and can express itself in functional disturbances experienced as sickness. We then make the diagnosis: neurosis.

What prevents these urges from being realized in active life?

It is one's habitually lived behavior pattern: sociologically expressed, a person's life role.

The role that one plays is important for the individual awareness that one is someone. Our daily reality is as much a function of our social role. On the other hand this role did receive, as it still does, its definition through reality.

This reality—the external world, the *Aussenwelt*—is by no means limited to objectively or scientifically determinable fact. Reality and its change represent a sociological problem with which we shall now deal.

II

First let us examine the therapeutic goal of traditional medicine.

It is the restoration of the patient, who expects of the physician what the physician expects of himself: that he restore the patient's health. But what "health" means is, sociologically speaking, by no means self-evident.

As von Uexküll[1] points out, " 'What is health?' is a question which arises only in a medical science which sees itself not solely as an institution of the contemporary society, but which recognizes itself as a science which is historically, sociologically, and culturally determined. We know today how greatly man's image of reality is determined by what each culture expects of its men, women, and children. In this way the current attitude of a culture determines what one expects of one's body. In turn medicine then formulates these expectations into the concepts with which it then approaches its task as a science.

"We must be aware that not only what we understand as 'health' and 'illness,' but also concepts such as 'body,' 'soul' and 'life' reflect very specific expectations which are predetermined by our culture."

Traditional medicine gauges health by performance. Thus our medicine sees as its task the restoration of bodily functions that enable the healthy person to perform the work by which he maintains his social standing. In addition, our times require a further performance of which the healthy person should be capable: namely, the socially imperative performance of consuming.

The medical task then would be to help the sick body to regain its optimal physiological function. "The aim of traditional medicine," says W. Schoene, "is not only the conservation of life, but the regaining of optimal physiological function for every patient. Medicine seeks to return each patient to the society as a fully functioning member."[2] Medicine cannot provide the patient's life with additional content. It can only make accessible to him again the culture that his illness forced him to leave.

In order that medicine may achieve what it can and should achieve, both doctor and patient must agree on the *purpose of health.* Moreover, both must agree with the society's health requirements. In the form of an insurance that pays for the treatment, the society shows how great is its interest in the collective health. Health is indeed the pre-

requisite for the existence of an industrial society, which is based on the general performance and readiness to work.

What are the sociological conditions that make possible this common consent about the therapeutic goals? Under what sociological conditions can this common consent in regard to the therapeutic goals persist?

First we must answer: as long as the required performance at work and in leisure time are able to provide the individual with self-assurance and expectations for the future. And that is: as long as they serve the achievement of status, common consent persists.

It is typical of the bourgeois trend of competition in the technical world that one's significance for others as well as for oneself must be achieved and sustained by performance. Health is a primary factor in the acquisition of status, i.e., the maintenance and improvement of the social position. Our traditional medicine has reached its goal. The general health, as a practical fitness of all, is at an all-time high, thanks to a scientifically oriented medicine available to all. How could it be that within this great and progressive medicine with its spectacular successes, a crisis appears that calls for a reexamination of its fundamental principles?

III

The cause cannot lie in medicine itself. It must lie in the fact that an increasing number of patients, sometimes consciously, more often unconsciously, do not want, are no longer able to want, *that* health which medicine can offer.

To begin with, they are not even aware of another kind of health. They have simply no desire for health. They sense that recovering their productive capacity would not help them. If Freud says neurosis brings with it secondary gains that manifest themselves in a resistance to recovery, we can say that the ill person whose illness resists every therapy may behave as if he knew that mere regaining of health is not rewarding enough.

We must not content ourselves with this information, but must ask whether these patients seek another dimension of health, a new way toward health, a new well-being that our medicine does not even provide.

We suspect this, but we must at the same time be aware that an

adequate therapeutic way could not have been discovered and used earlier because there was no demand for it.

IV

I shall now discuss the origin of this demand and its development.

When the physician encounters the corporeal refusal to regain normal functioning that manifests itself in a clinging to the illness, he is challenged to question the body in a new manner.

Here it is not the "tool function" of the body in the service of a healthy will to achieve, not its "instrumentality" that is important. For this patient, and therefore for his doctor, it is important to ask what the disturbance or, medically speaking, the symptom may *express*. Thus the symptom is not seen as a defect but as an access to the personal problems of the patient. Here the body is understood as a means of expression. Consequently the symptom must not be silenced, but made to speak. Here the patient does not turn his body over to the physician by an act of will. Here he has to become aware that he himself *is* his body, not merely *has* a body that—in case of illness—is disobedient. "*Er leibt und lebt.*"

The question, "Can medicine make me able to perform my work again?" moves into the background.

Into the foreground comes this question: "Who is it actually that has become ill in such a specific way, and by what procedure can this essence of the personality be reached?"

Seen in this way the new therapeutic style, as it appears in psychoanalysis, is the response to the incipient insight of modern man, that his suffering may be the expression of his having lost himself in the role of the forward-striving producer. In this role of the producer he became estranged from himself. But he knows himself exclusively in this role. The only sign of this estrangement is his uneasiness, his feeling of meaninglessness, of disinterest in his work, which cannot be compensated for by income or material gratification. Only in the course of the treatment, step by step, can the discovery take place. It cannot occur without anxiety. It is characteristic of psychoanalysis that in the very instant the patient comes closer to himself, he at the same time is afraid of losing himself. For the discovery that the previous role, which he called I, does not comprise all of him, makes apparent his own questionability and that of his world, before a new and safer self-assurance

can be built.

This becomes structured and apparent when we decisively commit ourselves to the expression of our immediate spontaneity: that is, what we feel to be our first nature, as the primordial nature of the child who, with the help of the parents and the intimate sphere of childhood, in order to become human, assumed the specific human form. This actually links us with our fellow men and with the world as our ancestors used to interpret it. It is offered to us as so-called reality, but is not this "reality" the mere traditional aspect of something infinitely more?

The free play of thoughts and associations, of phantasies and dreams, incline toward what we feel might be—but never actually will become in human life—our primordial directness. If we are inclined to go this way, we must overcome the barriers of guilt, of shame and disgust, and we must bear the anxiety that always arises when we try to overcome the indirectness of our everyday role and make a step toward our essential directness.

V

But what has happened in modern history to make the problem outlined here appear in contemporary man, and appear as illness?

What has been able to interfere to such an extent with the pleasure in achievement with its gratifications, wealth, and improved social status, that a new medicosocial problem arose?

We assume that disturbances of this sort showed up already in the 19th century, presumably following the "enlightenment." These disturbances accompanied the victory of the bourgeois, but man has only begun to understand them since the turn of the century, thanks to psychoanalysis. Since Freud, we know that to become stranded in life's struggle, to fail in daily life, is not due so much to incompetence as to a deep aversion towards the generally accepted concept of health. The individual fails in the competition because it simply does not offer him enough satisfaction.

Freud discovered that the motivations for these strange sufferings were problems of early childhood.

Only in the intimate sphere of the family group does each person become human. We must learn how to be humans. Thus, we not only learn to speak, to stand upright, to walk, to deal with objects, but we learn a specific language, the mother tongue; we learn the approved

way of walking, of standing, and of dealing with objects. That is, we learn to recognize the use-relationships in which the surrounding objects should appear to us. This relationship determines not only the way in which we deal with them, but in which we realize our whole world.

Being a man always means being a fellow-man; child of a specific epoch; member of a people. Man's status is determined by the family he belongs to, and in which he learned to become human.

Every man has a status to which he is born. In the role in which his origins place him, he experiences his first social recognition. Here we speak of "*ascribed status*," which is not diligently acquired but is determined by the tradition.

Also the ascribed status is "willed," not by the individual but by the tradition that the parents represent. It is their gift.

Helmut Plessner[3] writes: "Human existence realizes itself as an ever renewed act of incorporation. We create with this act the basis on which we raise ourselves to that which we may use as a support: the social structure which in a derived sense incorporates us as someone with name and status. Only thus do we become persons. The process of personification which the child begins at birth, makes the individual, for himself as for others, into an individual in that it gives him a name through which he can be spoken to. The giving of a name is a seal of an indisputable unit. Just as we ourselves must learn to stand, to walk, and to speak so does this self find its support in the name, both within itself and in the outer world. By means of his name the individual finds his place in the society, his status."

In our society the ascribed status has become of limited value and only an acquired status seems to have real value. This is dependent on our own performance and efficiency.

We may assume that our world begins finally to get free of the last vestiges of a traditional formation, which is given to us through the educational influence in our early childhood. Today, however, we begin to realize that this is by no means entirely beneficial.

It soon becomes apparent that success in achieving status—success here not only in the outer sense, but understood also as inner satisfaction—needs a certain security based on the ascribed status with which one entered the world. The paternal authority is instrumental in establishing this status.

Life under the direction of the internalized father is characteristic of the bourgeois society. So long as the relationship between father and son is taken for granted this life is without conflict and successful. We can then speak of a harmony of roles between parents and children. The father, with his own behavior, sets the example of how one should be.

David Riesman[4] describes the "inner-directed man" as one who must throughout his life embody the father in his role as authority. Freud says: he has incorporated him. "The father or parental authority projected into the ego constitutes there the core of the superego."[5]

VI

Already toward the end of the 19th century the harmony of roles between the generations was significantly disturbed. That generation of sons to which Sigmund Freud belonged was to free itself from paternal domination. The first insights of psychoanalysis were due to the decreasing harmony of roles and to the accompanying conflict between the generations with its consequent neuroses.

The conflicts that find expression in the psychoanalytic cure were seen to be concerned with paternal authority. Furthermore, it appeared that being tied to the parents was the obstacle that interfered with the striving for personal independence. The conflicting aspects of the intimate link to the parents, under the name of Oedipus complex, became the object of psychoanalysis. Herewith the *love problem* came into the foreground as disappointment, fixation, desire, love-addiction, and longing for love. Therefore, in closest connection with the pathology of the early childhood relationship and its conflicts, the theme of love-passion in early childhood, that is, infantile sexuality, became important.

What Freud calls *libido* (sex drive, Eros) is the inclusive concept of all those compulsively experienced strivings that seek toward human completion as an amalgamating union with a partner (Freud says with a love object). But when do these experiences of being driven so come to the fore that we become aware of them, and that we then are able to abstract "drive" as a theoretical concept? They appear when discrepancies arise in the harmony of roles among the members of the traditionally closely knitted groups of the family.

The problems that psychoanalysis discovered point to a relationship

between child and parents in the primordial intimate sphere, which has become questionable and conflict-laden.

VII

In the beginning the authority conflict was seen in the light of a freeing to act and judge in a way that does justice to reality. Today it is seen in another light. Today we encounter increasingly an absence of paternal authority, as well as of maternal warmth in that early period of humanization: a new theme is revealed to psychoanalysis through the neurotic problems of life.

The way leads from the "father-authoritarian" to the "fatherless" society.[6]

The consequences of suffering under paternal authority are replaced by the pathological consequences of a virtual parentlessness.

In the era when analysis began, overwhelmingly authoritarian parents prevented certain spontaneous demands from taking shape. Parental prohibitions and commandments forced children obediently to keep in check their forbidden urges. Psychoanalysis called this "repression." Under certain circumstances the reaction formation to this is neurosis.

Another kind of parental problem occupies today's generation of patients. The parents have allowed anything and everything. Whatever the child desired, they have placed at his disposal. They have omitted any kind of discipline and the child has been left undisciplined by the primordial parental influence. He therefore lacks self-assurance. The parents had only one concern: their children should not disturb them in their own efforts to improve, display, and live up to their status. They concerned themselves less with the creation of a homelike atmosphere and its meaning for becoming human than with the achievement that assured social prestige and career. In this connection an interesting investigation has been made by Annemarie Dührssen:[7] she proved that children from families that have intensive climbing tendencies have more neuroses than comparable children in a control group. In these cases the care of the children is limited and done without affective balance.

Psychoanalysis originated as an answer to the crisis of the "inner-directed" man. Today it finds itself confronted with the more difficult problem of the "other-directed" man.

The "other-directed" person lacks the unequivocal responsible par-

ental concern. He never did experience himself as belonging to his procreators. He experienced this lack as homelessness and a lack of belongingness. "The Oedipus complex," says Mitscherlich, "is replaced by the Kaspar Hauser complex."[8] (Kaspar Hauser was a German prince who, for political reasons, was reared by a peasant in a stable with animals; when, as a youth, he became free, he could scarcely speak.)

The relationship to parents and siblings becomes meaningless. The relationship to peer groups, which change continually from kindergarten to professional and recreational groups, are decisive for the social role.

This relationship adjusts itself to whatever trend happens to rule the group at the moment. Naturally the individual seeks out groups whose basic trend "appeals to him." If animosity and rebellion prevail, aggressive groups are chosen. Groups held together by sexual tendencies attract those who are sexually susceptible because they attempt to compensate for lack of love by bodily nearness. Naturally these groups are not mutually exclusive.

Not achievement, in the bourgeois sense, but passions determine the groups to which these passionate longings lead them. If the contact succeeds, these groups provide a feeling of absolute belonging. The individuals of the group become almost relatives. The relatedness that was scarcely experienced in early childhood now becomes real. By relating, the homeless one seeks to achieve that status which he did not receive through his parents. You cannot choose your parents, you can only interpret them, but you can choose your group. The group is chosen in the passionate expectation that it will assign that status which gives basic security in the wider world, status through which we obtain "primordial trust" (Erikson[9]).

In many cases this contact is not successful, or succeeds only for a short time. Then a neurosis may develop that leads to the doctor.

Here pathological disturbances cannot be traced back to authoritarian restrictions and father-determined rigidity. No longer does critical work with the analyst bring to light a sense of proportion and value hitherto hidden and finding its expression only in dreams and phantasies.

The disturbances that lead *this* generation of men to the doctor are signs of a lack of every intimate value, an absence of any foundation, which threatens to make all our commissions and omissions without

sense or purpose.

These people are insecure because their parents and the society in which these parents are based are no longer able to give them any status that provides them with an independent core of self-confidence, self-assurance, and independence, any role which their actual environment prescribes or ascribes.

Patient and doctor are today faced with the task of establishing self-assurance that is independent of achievement, in order to provide the patient with the basic security in the society, the "primordial trust," which carries him through all the changing roles he will necessarily play.

As I have already stated, the parents have not been able to give, even inadequately, this intimate security, which in the confrontation with the authoritarian transference figure could be modified and adapted to the demands of reality with the help of the transference analysis.

The homeless one must experience the analyst differently. He has been able to experience self-assurance only in fragments within one group or another to which he belonged for a longer or shorter time. He must experience the analyst not as the authoritarian father-ideal, but as representative and spokesman for an ideal group that will finally receive him and give him meaning and purpose.

It seems to me that a certain degree of uprootedness, as we meet it throughout the world in the young generation, inhibits our being able to see the values that people want to realize by psychoanalysis. One is unable to want an individual psychoanalytic treatment as long as its aim, to develop a sound and independent personality, lies out of reach. A person who has never experienced belonging could never attain an individual status with its specific conflicts.

Such people may also become prepared for psychoanalysis by a group treatment, psychoanalytically oriented or not. Group treatments can reveal and develop the vital values of togetherness and of common purposes. The endeavor of incorporating in the group is able to provoke only those individual inner conflicts which—in certain circumstances—may challenge the desire for an intimate encounter, referring to one's own personality. This, however, is the *conditio sine qua non* of any psychoanalytic treatment.

I presume that group analysis and other parametrical (often rather

arbitrary) techniques that are discussed in and between psychoanalytic groups are responses to the changing problems of psychotherapeutic approach, due to a changing social structure.

VIII

We have seen that the medical tasks are assigned by our patients.

In our time new afflictions have arisen to which new hopes for healing correspond. They demand a new therapeutic style. It has been my intention to show that psychoanalysis has attempted to do justice to these demands.

Cultures have always designated someone to deal with those who had lost the right way and had entangled themselves in wrongdoing. Of old the priest embodied this function. The sufferers turned to him, not to the doctor. They felt sinful, not ill.

What in our time has caused these perplexed persons to feel ill, even to be ill, so that they have forced the healing arts to develop a new kind of therapy?

The prerequisite for feeling sinful is a belief anchored in the common consent. The charisma of priestly authority is derived from this. This prerequisite no longer exists. There is no longer an authority who can show the way of expiation through confession and repentance, penance and conversion, in the literal sense of these words.

The person who today cannot deal with life and is entangled in his contradictions feels sick, for all attempts to do right have no influence on his condition. No authority can set him aright. It is no longer a matter of right and wrong but of being or not being, of meaning or meaninglessness. The moral question has become an existential one.

The discomfort that can grow into senseless anxiety is thus neither guilt nor sin, but illness. It is a deficiency that requires other remedies than doing right in a specific way.

In psychoanalytic treatment the patient becomes aware that he must develop a new attitude and a new way of thinking in which he can actually live meaningfully. This is an attitude in which he can fully recognize himself, not only as the one that he ideally *should* be, but as the one that in reality he *could* be.

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